The Health of New Hampshire's Community Hospital System

A Financial Analysis

Wentworth Douglass Hospital




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An Important Message to Readers of the Hospital Financial Analysis from the New Hampshire Department of Health and Human Services

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Introduction

The following Hospital Financial Analysis is a byproduct of the December 13 report, *The Health of New Hampshire's Community Hospital System*, issued by the New Hampshire Department of Health and Human Services. The individual financial narratives are part of a series of analyses addressing the financial condition of the state's health care system.

In the following report, you will find an analysis of the hospital's financial well being from 1993-1998, and **then an additional analysis** that covers the most recent period for which information is currently available, 1999. As audited financial statements for 2000 become available from the hospitals, this information will be updated.

Each hospital financial analysis is broken into five sections. These include:

- Background information on the hospital size, location, payor mix and affiliates;
- A Summary of the Financial Analysis;
- A Cash Flow Analysis;
- An Analysis of Profitability, Liquidity and Capital; and
- An Estimation of Charity Care and Community Benefits

Financial Benchmarks

Financial benchmarks include traditional measures of profitability, liquidity, solvency, and cash flow. Each of these areas of analysis is defined below. Additional information about the ratios or the nature of financial analysis can be obtained by consulting health care financial texts (Gibson 1992; Cleverley 1992).

Profitability:	Purpose	Calculation
Total Margin	Measures the organization's ability to cover expenses with revenues from all sources	Ratio of (Operating Income and Nonoperating Revenues)/Total Revenues
Operating Margin	Measures the organization's ability to cover operating expenses with operating revenues	Ratio of Operating Income/Total Operating Revenue
PPS Payment/Cost	Measures the relationship between Medicare PPS payments and Medicare PPS costs; numbers above 1 indicate that payments exceed costs	Ratio of Medicare Prospective Payment System (PPS) Payments /PPS Costs, derived from Medicare Cost Reports
Non-PPS Payment/Cost	Measures the relationship between payment and costs of all payment sources other than Medicare PPS[1]	Ratio of (Total Operating Revenue minus PPS Payments) / (Total Operating Cost minus PPS Costs)
Markup Ratio	Measures the relationship between hospital-set charges and hospital operating costs; generally only self-pay and indemnity payers pay hospital charges	Ratio of (Gross Patient Service Charges Plus Other Operating Revenue) / Total Operating Expense
Deductible Ratio	Measures the relationship between hospital's contractual discounts negotiated with (private payers) or taken by payers (Medicare and Medicaid) and hospital charges	Ratio of Contractual Adjustments/Gross Patient Service Revenue
Nonoperating Revenue Contribution	Measures the contribution of nonoperating revenues (activities that are peripheral to a hospital's central mission) to total surplus or deficit	Ratio of Nonoperating Revenues (includes unrestricted donations, investment income, realized gains (losses) on investments and peripheral activities)/Excess Revenue over Expense
Realized Gains to Net Income	Measures the contribution of realized gains (a subset of nonoperating revenues) to total surplus or deficit	Ratio of realized gains (losses)/Excess Revenue over Expense

[1] Medicare's Prospective Payment System includes only inpatient-related operating and capital costs and excludes Medicare payments for outpatient costs, which have not been part of PPS through 1998

Liquidity:		
Current Ratio	Measures the extent to which current assets are available to meet current liabilities	Current Assets/Current Liabilities
Days in Accounts Receivables	Measures how quickly revenues are collected from patients/payers	Patient Accounts Receivable/(Net Patient Service Revenue / 365)
Average Pay Period	Measures how quickly employees and outside vendors are paid by the hospital	(Accounts Payable and Accrued Expenses)/ (Average Daily Cash Operating Expenses)[2]
Days Cash on Hand	Measures how many days the hospital could continue to operate if no additional cash were collected	(Cash plus short-term investments plus noncurrent investments classified as Board Designated)/(Average Daily Cash Operating Expenses)
Solvency:		
Equity Financing Ratio	Measures the percentage of the hospital's capital structure that is equity (as opposed to debt, which must be repaid)	Unrestricted Net Assets/Total Assets
Cash Flow to Total Debt	Measures the ability of the hospital to pay off all debt with cash generated by operating and nonoperating activities	(Total Surplus (Deficit) plus Depreciation and Amortization Expense)/Total Liabilities
Average Age of Plant	Measures the relative age of fixed assets	Accumulated Depreciation/ Depreciation Expense

Hospitals As Integrated Systems of Care

Many of New Hampshire's hospitals have developed into systems of care with complex corporate organizational structures. Hospitals may be owned by a holding company or may themselves own other subsidiaries. (The hospital corporate organization charts will be made available with these financial narratives at a future date.) These individual analyses that follow attempt to isolate the hospital entity to the extent possible as the basis of analysis. This distinction is important because subsidiaries that operate within a larger hospital system may operate at higher or lower levels of financial performance than the hospital. For example, a home health agency impacted by Medicare reimbursement changes that result in an operating deficit might be directly supported by the hospital. On the other hand, an ambulatory surgical unit (or another entity within the holding company of which the hospital is a part of) with a healthy financial performance could have a positive impact on the hospital with an operating deficit.

[2] (Operating Expenses Less Depreciation Expense Less Bad Debt Expense)/365

Charity Care and Community Benefits

Each hospital financial analysis includes a section on Charity Care and Community Benefits. This section of the hospital financial narrative is more exploratory than are the other standardized financial benchmarks. For further background information or for specific information on how these measures were calculated, please see the *Analysis of Health Care Charitable Trusts in the State of New Hampshire.*

In 1999, the legislature passed the New Hampshire Community Benefits law (SB 69), which requires that all non-profit hospitals and other health care charitable trusts with $100,000 or more in their total fund balance complete a needs assessment of the communities that they serve. The legislation also calls for the hospitals and others to consult with members of the public within their communities to discuss what the provider has done in the past to meet community needs, what it plans to do in the future, and then submit the plan to the Attorney General's office.

New Hampshire's law is a reporting statute. It does not contain a dollar value or minimum threshold the non-profit trusts must meet. With this new statute, the hospitals and others are working to improve the measurement of charity care (free care) and other community benefits they provide in return for exemption from local, state and federal taxes. Since this law is relatively new, the audited financial statements used for the purpose of this community benefit analysis may not yet fully reflect the dollar value of community benefits beyond charges foregone for charity care or necessary but unprofitable services. New Hampshire's definition of community benefits is very broad; it includes free care but does not include bad debt or shortfalls in reimbursement from the Medicare and Medicaid programs.

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For More Information

Questions or comment concerning this report may be directed to the Office of Planning and Research at 603-271-5254.

MOODY'S BOND RATING: AAA

WENTWORTH DOUGLASS HOSPITAL
DOVER, NEW HAMPSHIRE
1993 – 1998 FINANCIAL ANALYSIS

Wentworth Douglass Hospital is a 178-bed, acute-care facility providing inpatient and outpatient services primarily to residents of Strafford County (New Hampshire) and Southern York County (Maine)[3]. As of 1997, private insurers and Medicare represented the largest percentage of payers for inpatient discharges (45 and 41%, respectively)[4].

In 1994, the hospital merged with Squamscott Home Health, Inc., an organization providing nursing and other home care services, hospice care and other medical services in the Dover area. The hospital wholly owns the for-profit Wentworth Douglass Community Health Corporation (WDCHC), which was formed in 1995 and subsequently purchased an athletic club that same year. WDCHC is accounted for by the equity method. Other equity investments include Strafford Health Alliance, Health Circle, Inc., (both co-owned by Frisbie Memorial Hospital) and Occupational Health Solutions of New England. In 1998, the not-for-profit Wentworth Douglass Physician Corporation controlled by Wentworth Douglass Hospital was formed.

Financial data represent the hospital only. Gross patient service revenues were not disclosed in the footnotes to the audited statements. Therefore, we used Medicare Cost Report data available from 1993 to 1997 to obtain this information to enable us to evaluate markup and deductible and to benchmark the hospital's charitable commitment.

Summary of Financial Analysis 1993-98

Wentworth Douglass' financial performance over the period was strong. The hospital generated most of its cash internally, namely from depreciation and net income, to fund investments in marketable securities and plant. The priority on the former contributed to high profitability in recent years by generating investment income that enhanced the bottom line. Investments in marketable securities also bolstered the hospital's liquidity, resulting in large cash balances – 426 days in 1998. Strong and improving profitability, liquidity, and solvency measures illustrate the hospital's financial health.

Cash Flow Analysis 1993-98

Over the six-year period, the hospital generated 90% of its cash internally from depreciation (46%) and net income (44%). The hospital augmented these internal sources of cash with long-term borrowing, used mainly to turn over existing debt, though debt issued ($6.4M) exceeded the amount repaid ($4.9M).

The main investment priority was increasing marketable securities, mostly board-designated funds, which consumed half of the cash flows over the period. Even after decreasing the current cash account (5% of cash sources), the hospital used 45% of its cash flow to generate a large amount of liquidity. Investment in property, plant and equipment (PP&E), which comprised 40% of total cash uses ($25M), was slightly less than depreciation expense over the period ($30M). The steadily increasing age of plant after 1995 indicates that this level of investment was below

[3] The 1998 American Hospital Association Guide.
[4] 1997 data from the State of New Hampshire Department of Health and Human Services.

that needed to sustain the 1992 level of plant age (7.07). The hospital spent 10% of its cash on affiliates, increasing its equity investments ($3M) and making a $3.6M loan to its for-profit affiliate, WDCHC.

Ratio Analysis 1993-98[5]

Profitability

Profit margins were high and increased steadily over the period, driven largely by nonoperating revenues. Prior to 1995, strong operating margins drove overall profitability, but they dropped sharply in 1995 due to a drop in the markup of charges over cost. By 1997, however, the markup recovered and so did operating margins, which reached 7% in 1998. With the added contribution of nonoperating revenues to total income, 1998 was the hospital's most profitable year of the period covered, with a 14% total margin.

The contribution of nonoperating revenue to the bottom line became increasingly important from 1995 to 1996 when operating margins were depressed. In fact, the large amount of investment income contributed 83 to 89% of the bottom line in these years, producing 7 to 9% total margins despite near break-even operations. When the operating margin recovered in 1997, the hospital was able to generate high total margins due to the large amount of investment income resulting from its investment strategy.

Liquidity

The hospital is very liquid given its priority on investing in marketable securities. A low and declining current ratio was due mostly to a large increase in the third-party settlement account, an estimated liability. This liability account increased by eleven-fold over the five-year period, which may reflect a change in payer mix and/or increasing conservation in estimating revenues. The inclusion of unrestricted investments in the current ratio calculation indicates that the hospital can easily meet its current obligations.

The hospital has a strong cash position as illustrated by the days cash on hand measures. While the days cash on hand with short-term sources decreased over the period, the hospital maintained 42 days as of 1998. When unrestricted marketable securities are considered, the hospital's unrestricted cash balances reach 426 days in 1998. The large amount of liquidity available gives the hospital considerable strategic flexibility. (Note: The adoption in 1996 of an accounting policy change requiring certain investments to be stated at market value rather than cost contributed to the growth in the days cash with all sources measured between 1995 and 1996.)

Trends in working capital contributed to the hospital's ability to maintain large cash balances. The average pay period was fairly stable throughout the period, in the 50-58 day range. Days in accounts receivable decreased slightly over the period until 1998, when they increased to 74 days. The increase in both measures between 1993 and 1994 may have reflected the merger with Squamscott.

Capital Structure

The hospital is not highly leveraged, as illustrated by the equity financing ratio (equity/total unrestricted assets), which demonstrates that roughly two thirds of the hospital's assets are financed with equity. The increase in long-term borrowing in 1994 increased financial risk slightly; however, the level of financial risk steadily declined after 1994 as equity grew due to strong profitability. The above-mentioned accounting principal change may also have contributed

[5] NH state medians from The 1998-99 Almanac of Hospital Financial & Operating Indicators.

to the improvement in capital structure between 1995 and 1996 due to the effect of unrealized gains on equity.

Strong profitability produced improved debt coverage indicators. Debt service coverage ratios show that the hospital can meet yearly principal and interest payments with a large margin of safety, even with just operating income. The cash flow to total debt ratio also shows that the hospital generates enough yearly net income to cover approximately one-third of its total outstanding debt.

Charity Care and Community Benefits

Charity care reported as charges forgone represented less than 1% of gross patient revenues from 1993 to 1997. This amount of charity care did not meet the estimated value of the hospital's tax exemption. With the inclusion of 100% bad debt, charity care met the estimated tax liability from 1993 to 1996. 1998 is not included here because gross patient service revenues were not available; the Medicare Cost report data used for 1993 – 1997 was not yet available.

The hospital did not report additional charity care in the footnotes to its financial statements.

In addition to charity care, the hospital operates a trauma center, which may be considered an additional charitable benefit to the community[1].

Source: Audited Financial Statements. Prepared by Nancy M. Kane, D.B.A. Harvard School of Public Health